UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JEFFREY FARKAS, M.D. on assignments of Kahiga F., Denise L., Louis V., and Charles G.,	
Plaintiff,	**COMPLAINT**
v.	
EMPIRE BLUE CROSS BLUE SHIELD,	**DOCKET NO.: ____________**
Defendant.	

Plaintiff Jeffrey Farkas, M.D., on assignments from Kahiga F., Denise L., Louis V., and Charles G., by way of Complaint against Defendant Empire Blue Cross Blue Shield, alleges as follows:

THE PARTIES

1. At all relevant times, Plaintiff Jeffrey Farkas, M.D. ("Plaintiff") was a healthcare provider in the County of Kings, State of New York.
2. Upon information and belief, Defendant Empire Blue Cross Blue Shield ("Defendant") is primarily engaged in the business of providing and/or administering health care plans ("Plans") or policies ("Policies") and was present and engaged in significant activities in the State of New York to sustain this Court's exercise of *in personam* jurisdiction.

ANATOMY OF THE CLAIM

3. This dispute arises from Defendant's refusal to properly reimburse Plaintiff for emergency services provided to Defendant's beneficiaries, Kahiga F., Denise L., Louis V., and Charles G., ("Patients").

4. On various dates of service, Plaintiff provided emergency services to Patients, including emergency surgical treatments. *See* Medical Records, attached hereto as Exhibit A.

5. Plaintiff obtained written assignments of benefits ("AOB") from Kahiga F., Louis V., and Charles G., in order to bring this claim under the Employee Retirement Income Security Act of 1974, 29 USC §1002, *et seq.* ("ERISA"). *See* AOBs attached hereto as Exhibit B.

6. In addition, due to the emergent nature of the services at issue, assignments of benefits from Patients were implied.

7. Plaintiff prepared Health Insurance Claim Forms ("HICF") formally demanding reimbursement for Plaintiff's treatment of Patients. The total amount billed when accounting for all claims at issue is $186,230.62. *See* HICFs attached hereto as Exhibit C.

8. Defendant, however, only "allowed" a total of $20,141.21 towards payment for the above referenced emergency treatment. *See* EOBs, attached hereto as Exhibit D.

9. In at least one of Defendant's explanation of benefits, Defendant stated, "[s]ince this patient did not have the opportunity to select an in-network provider for these services, we are paying them at the in-network benefits level. We ask that you accept this payment and the in-network co-pay, deductible, coinsurance amounts, as payment in full." *Id.*

10. As indicated in the EOBs, Patients were unable to select an in-network provider because they were in need of emergency services. *Id.*

11. Patients therefore underwent treatment with Plaintiff, an out-of-network provider. *Id.*

12. Upon information and belief, and as indicated in the EOBs, Patients' health plans allow them to undergo emergency treatment with out-of-network providers and be held to the same cost-sharing liabilities as though they had undergone in-network treatment. *Id*.
13. Thus, Defendant "asked" Plaintiff in their EOB if Plaintiff would accept Defendant's underpayment as payment in full so that Patients would not incur additional cost-sharing for having undergone emergent out-of-network treatment.
14. However, for all the claims at issue, Plaintiff did not accept Defendant's underpayments – which amount to less than 10% of Plaintiff's bills – as payment in full.
15. Plaintiff engaged in the applicable administrative appeals process maintained by Defendant to inform that it was not accepting Defendant's payments as payment in full. *See* appeals, attached hereto as Exhibit E.
16. However, to date, Defendant has not remitted any additional payment.
17. Taking into account deductions, copayments and coinsurance, Defendant's reimbursements amount to a total underpayment of $165,106.29.
18. Accordingly, Plaintiff brings this action for recovery of the outstanding balance.

COUNT ONE

FAILURE TO MAKE ALL PAYMENTS PURSUANT TO MEMBER'S PLAN UNDER 29 U.S.C. § 1132(a)(1)(B)

19. Plaintiff repeats and re-alleges the allegations of Paragraphs 1-18 of this Complaint and incorporates same by reference hereto.

20. Plaintiff avers this Count to the extent ERISA governs this dispute.

21. Section 502(a)(1), codified at 29 U.S.C. § 1132(a) provides a cause of action for a beneficiary or participant seeking payment under a Plan.

22. Plaintiff has standing to seek such relief based on the assignment of benefits obtained by Plaintiff from Patients.

23. Upon information and belief, Defendant acted in a fiduciary capacity in administering any claims determined to be governed by ERISA.

24. Plaintiff is entitled to recover benefits due to Patient under any applicable ERISA Plan and Policy.

25. Upon information and belief, Defendant has failed to make payment pursuant to the controlling Plan or Policy.

26. Plaintiff also alleges that Defendant's decision to deny additional reimbursement was wrongful.

27. As a result, Plaintiff has been damaged and continues to suffer damages in the operation of its medical practice.

WHEREFORE, Plaintiff demands judgment against Defendant as follows:

a. For an Order directing Defendant to pay to Plaintiff $165,106.29;

b. For an Order directing Defendant to pay to Plaintiff all benefits Patient would be entitled to pursuant the Plan or Policy issued by Defendant;

c. For compensatory damages and interest;

d. For attorneys' fees and costs of suit; and

e. For such other and further relief as the Court may deem just and equitable.

COUNT TWO

BREACH OF FIDUCIARY DUTY AND CO-FIDUCIARY DUTY UNDER 29 U.S.C. § 1132(a)(3), 29 U.S.C. § 1104(a)(1) and 29 U.S.C. § 1105(a)

28. Plaintiff repeats and re-alleges the allegations of Paragraphs 1-27 of this Complaint and incorporates same by reference hereto.

29. 29 U.S.C. § 1132(a)(3)(B) provides a cause of action by a participant, beneficiary, or fiduciary to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

30. Plaintiff seeks redress for Defendant' breaches of fiduciary duty and/or breaches of co-fiduciary duty under 29 U.S.C. § 1132(a)(3)(B), 29 U.S.C. § 1104(a)(1) and 29 U.S.C. § 1105(a).

31. 29 U.S.C. § 1104(a)(1) imposes a "prudent man standard of care" on fiduciaries.

32. Specifically, a fiduciary shall discharge its duties with respect to a plan solely in the interest of the participants and beneficiaries and (A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan; (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; (C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and (D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter. 29 U.S.C. § 1104(a)(1)

33. 29 U.S.C. § 1105(a) imposes liability for breaches of co-fiduciaries.

34. Specifically, a fiduciary with respect to a plan shall be liable for a breach of fiduciary responsibility of another fiduciary with respect to the same plan in the following circumstances: (1) if he participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach; (2) if, by his failure to comply with section 1104(a)(1) ["prudent man standard of care] of this title in the

administration of his specific responsibilities which give rise to his status as a fiduciary, he has enabled such other fiduciary to commit a breach; or (3) if he has knowledge of a breach by such other fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach. 29 U.S.C. § 1105(a).

35. Here, when Defendant acted to deny payment for the medical bills at issue herein, and when they responded to the administrative appeals initiated by Plaintiff, they were clearly acting as a "fiduciary" as that term is defined by ERISA § 1002(21)(A) because, among other reasons, Defendant acted with discretionary authority or control to deny the payment and to manage the administration of the employee benefit plan at issue as described above.

36. Here, Defendant breached its fiduciary duties by:

a. Failing to issue an Adverse Benefit Determination in accordance with the requirements of ERISA and applicable regulations;

b. Participating knowingly in, or knowingly undertaking to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach;

c. Failing to make reasonable efforts under the circumstances to remedy the breach of such other fiduciary; and

d. Wrongfully withholding money belonging to Plaintiff.

WHEREFORE, Plaintiff demands judgment against Defendant as follows:

a. For an Order directing Defendant to pay to Plaintiff $165,106.29;

b. For an Order directing Defendant to pay to Plaintiff all benefits Patient would be entitled to pursuant the Plan or Policy issued by Defendant;

c. For compensatory damages and interest;

d. For attorneys' fees and costs of suit; and

e. For such other and further relief as the Court may deem just and equitable.

NOTICE TO PRODUCE

Pursuant to R. 4:18-1, Plaintiff hereby demands that each Defendant produce the following documentation within fifty (50) days as prescribed by the Rules of Court. Additionally please be advised that the following requests are ongoing and are continuing in nature and each Defendant is therefore required to continuously update its responses thereto as new information or documentation comes into existence.

1. A true and exact copy of any and all Health Insurance Policy, Summary Plan Description, and/or Plan describing the terms and conditions governing the patients who received services rendered by Plaintiff as described in the Complaint filed in this action.

2. Copies of representative documents (with private information redacted to comply with privacy laws) showing payments made by any Defendant entities to the same or similar healthcare provider as Plaintiff.

3. Copies of representative documents (with private information redacted to comply with privacy laws) showing payments made by the Plan to this healthcare provider and similar healthcare providers for comparable services as an in network service.

4. Copies of representative documents (with private information redacted to comply with privacy laws) showing payments made by the Plan to this healthcare provider and similar healthcare providers for comparable services as an out of network service.

5. The name, address and contact information of any other party of interest, specifically the Plan Administrator, Claims Administrator, Third-Party Administrator and /or additional Insurance Companies.

6. The name of the publication, database, documentation, Medicare guidelines etc., of all documents and databases used by Defendant in computing the Usual and Customary Rates or the reimbursement rate for out-of-network providers as defined by the relevant Plan.

7. Provide copies of any and all algorithm(s), formula(s), procedure(s) or fee schedule(s) used to derive the customary and reasonable reimbursement rate in this matter.

8. Copies of any and all documentation, including but not limited to manuals, statutes, rules, regulations, books and/or industry standards which refer to, reflect or otherwise relate to the date of service in question or any potential defense to the action in question.

9. If any Defendant intends to produce the testimony of any expert witnesses at Trial, set forth the names and addresses of each such witness, their area of expertise, the subject matter on which they are expected to testify, and a summary of the grounds of each opinion. Attach a true copy of all written reports provided the Defendant by such witnesses.

TRIAL COUNSEL DESIGNATION

Michael Gottlieb, Esq., is hereby designated as Trial Counsel in the above matter.

R. 4:5-1(b)(2) CERTIFICATION

Pursuant to R. 4:5-1(b)(2), I hereby certify that the matter in controversy is not the subject of any other action pending in any court, is not the subject of a pending arbitration proceeding and is not the subject of any other contemplated action or arbitration proceeding, except as may be set forth below:

None.

I further certify that I know of no non-parties who should be joined in the action pursuant to R. 4:28, or who may be subject to joinder pursuant to R. 4:29-1(b) because of potential liability to any party on the basis of the same transactional facts, except as may be set forth below:

None.

Dated: Paramus, New Jersey
March 29, 2017

Respectfully submitted,

CALLAGY LAW, P.C.

By: ______________________

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